		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0009258

Facility Name: Good Samaritan Home

Address: 2130 Harrison Street (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 223-8717 **Fax #** (217) 223-6015

IDPA ID Number: 370724112001

Date of Initial License for Current Owners: 2/22/1957

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Ms. Judy M. Graham **Telephone Number:** (217) 223-8717
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/03 to 9/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mr. Michael Duffy
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,836	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,312	3
4		Intermediate/DD			4
5	97	Sheltered Care (SC)	97	35,502	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,287	262	2,611	5,160	8
9	SNF/PED					9
10	ICF	20,977	59,999		80,976	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,264	60,261	2,611	86,136	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.58%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy - Pool Exercise Classes

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/22/57

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 8 and days of care provided 2,611

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	819,561	48,744	16,692	884,997		884,997		884,997			1
2	Food Purchase		670,705		670,705		670,705	(16,437)	654,268			2
3	Housekeeping	254,678	40,475	21,485	316,638		316,638	(3,900)	312,738			3
4	Laundry	108,074		18,501	126,575		126,575		126,575			4
5	Heat and Other Utilities			363,529	363,529		363,529		363,529			5
6	Maintenance	252,928	42,061	93,594	388,583		388,583	2,091	390,674			6
7	Other (specify):*											7
8	TOTAL General Services	1,435,241	801,985	513,801	2,751,027		2,751,027	(18,246)	2,732,781			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	3,922,621	245,030	33,082	4,200,733		4,200,733		4,200,733			10
10a	Therapy	70,962	2,174	254,766	327,902		327,902		327,902			10a
11	Activities	135,683	2,842	9,868	148,393		148,393		148,393			11
12	Social Services	126,460	1,006	846	128,312		128,312		128,312			12
13	Nurse Aide Training	9,061		1,804	10,865		10,865		10,865			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,264,787	251,052	303,966	4,819,805		4,819,805		4,819,805			16
	C. General Administration											
17	Administrative	173,334			173,334		173,334		173,334			17
18	Directors Fees											18
19	Professional Services			47,703	47,703		47,703	(433)	47,270			19
20	Dues, Fees, Subscriptions & Promotions			40,085	40,085		40,085	3,306	43,391			20
21	Clerical & General Office Expenses	379,771	39,519	74,310	493,600		493,600	(43,555)	450,045			21
22	Employee Benefits & Payroll Taxes			1,207,413	1,207,413		1,207,413		1,207,413			22
23	Inservice Training & Education			3,952	3,952		3,952		3,952			23
24	Travel and Seminar			13,212	13,212		13,212	(224)	12,988			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			179,675	179,675		179,675		179,675			26
27	Other (specify):*											27
28	TOTAL General Administration	553,105	39,519	1,566,350	2,158,974		2,158,974	(40,906)	2,118,068			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,253,133	1,092,556	2,384,117	9,729,806		9,729,806	(59,152)	9,670,654			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification
**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Good Samaritan Home #0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			438,167	438,167		438,167	(7,726)	430,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			438,167	438,167		438,167	(7,726)	430,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,197		58,197		58,197		58,197			39
40	Barber and Beauty Shops	48,716	3,845	407	52,968		52,968		52,968			40
41	Coffee and Gift Shops	20,258	27,739		47,997		47,997		47,997			41
42	Provider Participation Fee			97,722	97,722		97,722		97,722			42
43	Other (specify):* Nonallowable Costs	63,231		756,499	819,730		819,730	(819,730)				43
44	**TOTAL Special Cost Centers**	132,205	89,781	854,628	1,076,614		1,076,614	(819,730)	256,884			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,385,338	1,182,337	3,676,912	11,244,587		11,244,587	(886,608)	10,357,979			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(16,437)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,494)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,787)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,525)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attach Sch 5A	(799,365)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (886,608)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (886,608)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Good Samaritan Home
0009258
9/30/04

Schedule

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Out of period legal fees	(183)	19
Facility License Expense	3,750	21
To disallow Chamber of Commerce and Kiwanis Club dues	(444)	20
To disallow Rotary & Kiwanis Club dues	(528)	21
To disallow out of state travel	0	24
To record deferred Maintenance Expense for year	2,091	6
To disallow radio station expense	(632)	43
To disallow X-Ray expense	(942)	43
To disallow Lab expense	(5,531)	43
To disallow investment consultants	(226,020)	43
To disallow out of period seminar cost	(1,113)	24
To record last year out of period cost for seminars that related to this y	889	24
To offset guest room income	(2,232)	30
To disallow cottage service income	(3,900)	3
To offset miscellaneous income	(8,779)	21
To offset discount earned income	(481)	21
To disallow Property Taxes	(6,894)	43
To disallow rental property expenses	(7,862)	43
To disallow radio station depreciation	(26)	43
To disallow cottage expenses	(506,511)	43
To disallow Development expense	(250)	19
To disallow Public Relation Wages	(33,767)	21
Total	**(799,365)**	

5A

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/03

Ending: 9/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/03 **Ending:** 9/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(16,437)	0	0	0	0	0	0	0	0	0	0	(16,437)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,437)	0	0	0	0	0	0	0	0	0	0	(16,437)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,437)	0	0	0	0	0	0	0	0	0	0	(16,437)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/03 **Ending:** 9/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(5,494)	0	0	0	0	0	0	0	0	0	0	(5,494)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,494)	0	0	0	0	0	0	0	0	0	0	(5,494)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(65,312)	0	0	0	0	0	0	0	0	0	0	(65,312)	43
44	**TOTAL Special Cost Centers**	(65,312)	0	0	0	0	0	0	0	0	0	0	(65,312)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,243)	0	0	0	0	0	0	0	0	0	0	(87,243)	45

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3		N/A								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.	N/A		$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 169,463 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Residential Cottage Apartments 160 units for 174,278 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	1,219,680	1956-1999	$ 128,278	1
2					2
3	TOTALS	1,219,680		$ 128,278	3

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30			1957	$ 358,309	$	40	$	$	$ 358,309	4
5	75			1962	683,823		40			683,823	5
6	99			1973	1,683,761	42,094	40	42,094		1,300,017	6
7	75			1984	1,953,541	48,839	40	48,839		1,005,263	7
8											8
	Improvement Type**										
9	Building Service Equipment			1973	38,904		20			38,904	9
10	Land Improvements			1974	26,525	29	30	29		26,524	10
11	Building Improvements			1974	89,670	589	30	589		89,670	11
12	Building Improvements			1975	28,553		20			28,553	12
13	Building Improvements			1976	9,414		20			9,414	13
14	Building Improvements			1977	3,107		20			3,107	14
15	Building Service Equipment			1978	5,714		15			5,714	15
16	Building Improvements			1979	179		20			179	16
17	Building Service Equipment			1979	9,188		Various			9,188	17
18	Building Service Equipment			1980	1,596		Various			1,596	18
19	Building Improvements			1982	151,081	4,555	Various	4,555		117,288	19
20	Building Service Equipment			1982	17,350		Various			17,350	20
21	Building Service Equipment			1983	10,058		20			10,058	21
22	Land Improvements			1984	49,187		15			49,187	22
23	Building Service Equipment			1984	816,496	7,407	Various	7,407		812,494	23
24	Land Improvements			1985	29,707	1,355	20	1,355		28,123	24
25	Building Improvements			1985	250,935	6,273	40	6,273		120,869	25
26	Building Service Equipment			1985	184,917	8,643	Various	8,643		179,918	26
27	Land Improvements			1986	72,453	3,430	20	3,430		67,025	27
28	Building Improvements			1986	161,531	4,038	40	4,038		73,597	28
29	Building Service Equipment			1986	137,391	6,241	Various	6,241		114,055	29
30	Building Improvements			1987	19,089	500	Various	500		8,465	30
31	Building Service Equipment			1987	21,221	1,061	20	1,061		18,387	31
32	Land Improvements			1988	19,174	891	20	891		15,612	32
33	Building Service Equipment			1988	14,400	43	Various	43		14,034	33
34	Building Improvements			1989	174,123	4,421	Various	4,421		112,768	34
35	Building Service Equipment			1989	6,469	113	Various	113		6,469	35
36	Garage Additions			1990	78,563	2,619	30	2,619		38,408	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Roof - North Wing	1990	$ 43,980	$ 2,199	20	$ 2,199	$	$ 31,702	37
38	Phones	1990	600		10			600	38
39	Hall Renovations	1991	20,616	1,031	20	1,031		14,002	39
40	Building Improvements State Audit Adjustments 10881+30372	1991	511,992	18,441	30	17,066	(1,375)	227,494	40
41	Ceiling/partitions	1991	37,276	1,243	30	1,243		16,567	41
42	Office Entrance	1991	14,768	738	20	738		10,338	42
43	Building Services Equipment State Aduit Adjustment of 35	1991	83,893	1,465	various	1,441	(24)	82,234	43
44	Parking Lot	1992	4,257	213	20	213		2,341	44
45	Building Services Equipment	1992	2,706		10			2,706	45
46	Parking Lot	1992	46,071	2,303	20	2,303		26,683	46
47	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		87,950	47
48	Building Services Equipment	1993	20,910	238	various	238		17,603	48
49	Parking Lot	1994	87,827	5,855	15	5,855		62,943	49
50	Manhole/Sewer	1994	2,859	191	15	191		2,033	50
51	Sidewalk	1994	7,875	525	15	525		5,294	51
52	West Nursing	1994	66,876	3,344	20	3,344		33,438	52
53	Dining Room	1994	6,990	350	various	350		4,153	53
54	Building Services Equipment	1994	134,323	4,531	various	4,531		108,510	54
55	West Nursing	1995	128,327	6,416	20	6,416		61,490	55
56	West Nursing	1995	3,151	158	20	158		1,339	56
57	Building Services Equipment	1995	22,482	1,469	various	1,469		17,754	57
58	Gas Line	1996	3,062	153	20	153		1,301	58
59	Gutters	1996	10,817	541	20	541		4,597	59
60	Eber Wing Improvements	1996	20,335	1,017	20	1,017		8,642	60
61	Roof	1996	9,016	451	20	451		3,832	61
62	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		28,025	62
63	Building Services Equipment	1996	46,663	2,950	various	2,950		25,077	63
64	Lights/Front Land Improvements	1997	5,360	357	15	357		2,769	64
65	Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		15,668	65
66	Freezer Floor	1997	4,394	258	17	258		2,068	66
67	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		8,565	67
68	Sprinkling System	1997	3,354	335	10	335		2,180	68
69	Tamper Detectors	1997	2,818	282	10	282		1,832	69
70	TOTAL (lines 4 thru 69)		$ 8,931,759	$ 214,834		$ 213,435	$ (1,399)	$ 6,286,098	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,931,759	$ 214,834		$ 213,435	$ (1,399)	$ 6,286,098	1
2	Compressor - Eber	1997	2,039	136	15	136		997	2
3	Compressor - East	1997	11,808	787	15	787		5,707	3
4	Sprinkler System	1997	102,875	5,144	20	5,144		36,435	4
5	Air Exchange -Pool Area State Audit adjustment 480	1997	8,092	572	15	539	(33)	3,908	5
6	Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		7,880	6
7	Elevator Doors Dietary	1998	1,095	110	10	110		712	7
8	Underground Tanks	1998	23,092	2,309	10	2,309		15,010	8
9	Remodeling -Anna Brow Wing Walls, Celing, Floors,Lights	1999	199,131	4,978	39	4,978		25,928	9
10	Remodeling -Anna Brow Wing - Duct Detectors	1999	1,444	144	5	144		1,444	10
11	Remodeling -Anna Brow Wing - Carpeting	1999	2,966	297	10	297		1,631	11
12	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	548	39	548		2,945	12
13	Chapel Roof	1999	21,515	538	39	538		3,160	13
14	Fire Damper Alarm	1999	5,490	549	5	549		5,490	14
15	Eber Parking Lot Lights	1999	5,495	366	15	366		2,014	15
16	Lawn	1999	661	66	5	66		661	16
17	Stainless Steel D/W Exhaust	1999	1,659	166	10	166		912	17
18	Wiring Chapel Roof	1999	332	33	10	33		183	18
19	HVAC Chapel	1999	23,760	1,584	15	1,584		8,712	19
20	Code Alert System	1999	61,985	6,199	5	6,199		61,985	20
21	Elevator Upgrade A/B East	1999	22,556	2,256	10	2,256		12,406	21
22	Elevator Upgrade - Special Care	1999	5,970	597	10	597		3,284	22
23	Fire Protection A/B	1999	4,500	450	10	450		2,475	23
24	Condensor Unit	1999	22,945	1,530	15	1,530		8,413	24
25	Fire Proctection Pool Area	1999	776	78	10	78		427	25
26	Damper Duct Work	1999	5,602	373	15	373		2,054	26
27	Lighting- Special Care	1999	2,075	138	15	138		761	27
28	Chapel Remodeling - Fire Damper	2000	3,196	213	15	213		959	28
29	Chapel Remodeling - Sign	2000	77	15	5	15		70	29
30	Chapel Remodeling - Painting	2000	4,751	119	39	119		481	30
31	Chapel Remodeling - Carpeting	2000	3,073	205	15	205		922	31
32	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		1,491	32
33	Kitchen Remodeling - Hood	2000	2,511	167	15	167		753	33
34	TOTAL (lines 1 thru 33)		$ 9,565,455	$ 247,038		$ 245,606	$ (1,432)	$ 6,506,308	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,565,455	$ 247,038		$ 245,606	$ (1,432)	$ 6,506,308	1
2	Kitchen Remodeling - Sky Roof Flashing	2000	3,086	206	15	206		927	2
3	Kitchen Remodeling - Sidewalls	2000	3,485	232	15	232		1,045	3
4	Kitchen Remodeling - Galvanized Wall Divider	2000	2,601	173	15	173		780	4
5	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		2,871	5
6	Eber Wing Smoke Damper	2000	16,485	1,099	15	1,099		4,946	6
7	Special Care Lighting	2000	14,290	953	15	953		4,287	7
8	HVAC Rehab Eber Wing	2000	305,419	20,361	15	20,361		91,626	8
9	Groundkeeper	2000	5,298	757	7	757		3,406	9
10	3 Ton Rooftop Unit A/C West Dining	2000	2,776	185	15	185		833	10
11	Telephone Unit	2000	323	46	7	46		208	11
12	Elevator Up Grade East Wing	2000	12,776	852	15	852		3,833	12
13	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		330	13
14	Entrance Codelock Special Care	2000	1,848	123	15	123		554	14
15	Life Safety Code Sprinkler Drains	2000	7,000	467	15	467		2,101	15
16	Land Improvement New Sidewalk	2000	1,200	60	20	60		210	16
17	Renovation of East nursing Wing	2001	369,213	9,230	39	9,230		29,614	17
18	Exterior Painting	2001	14,347	956	15	956		3,348	18
19	Painting Kitchen	2001	2,550	170	15	170		595	19
20	Chapel Renovation	2000	2,001	50	39	50		194	20
21	Kitchen Electrical Work	2000	611	41	15	41		143	21
22	HVAC Rehab Eber Wing	2000	5,584	372	15	372		1,303	22
23	Sprinklers	2000	4,151	277	15	277		969	23
24	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		862	24
25	Electrical Work	2001	1,609	107	15	107		375	25
26	Smoke/ Fire Damper East, South and Eber	2001	50,735	3,382	15	3,382		11,838	26
27	Air Compressor Anna Brown Wing	2001	10,911	728	15	728		2,546	27
28	3D Detectors in Elevators	2001	4,916	418	10	418		1,156	28
29	Exhaust fan	2001	1,815	154	10	154		426	29
30	Compensators	2001	2,724	232	10	232		640	30
31	33 Lever Passage Locks	2002	2,904	247	10	247		682	31
32	Exit Lights and Hold Opens	2002	966	82	10	82		227	32
33	16 Lever Passage Locks	2002	1,408	120	10	120		331	33
34	TOTAL (lines 1 thru 33)		$ 10,450,040	$ 290,106		$ 288,674	$ (1,432)	$ 6,679,514	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,450,040	$ 290,106		$ 288,674	$ (1,432)	$ 6,679,514	1
2	48 Lockouts	2002	985	84	10	84		231	2
3	Water Piping	2001	4,600	115	39	115		331	3
4	New Curb & Driveway	2002	16,118	745	20	745		1,954	4
5	Buffet in Dining Area	2003	2,977	198	15	198		333	5
6	Door - code alert and keypad	2003	2,489	249	10	249		415	6
7	Fire Collars	2003	3,619	362	10	362		586	7
8	Kitchen Exhaust Fans	2003	2,663	266	10	266		310	8
9	Main Breaker	2003	3,291	219	15	219		238	9
10	Elevator Master Door Operator	2003	4,278	428	10	428		606	10
11	Training Room Drainage	2003	731	19	39	19		28	11
12	Dietary - Floor Drain	2003	223	6	39	6		8	12
13	Handicap Accessible Entrance and Sidewalk	2003	3,200	160	20	160		160	13
14	Annunciators	2004	51,494	2,575	10	2,575		2,575	14
15	Sewer Lines	2003	5,801	355	15	355		355	15
16	Smoke Damper - Eber	2003	698	39	15	39		39	16
17	Beauty Shop Wiring	2003	2,272	114	15	114		114	17
18	Dietary Doors	2004	3,801	169	15	169		169	18
19	Roof	2004	4,028	134	15	134		134	19
20	Remote Annunciator	2004	4,650	155	10	155		155	20
21	Cooler Expansion	2004	6,120	136	15	136		136	21
22	Parking Lot	2004	6,800	113	15	113		113	22
23	Ambulance Garage Doors	2004	1,070	18	10	18		18	23
24	Kitchen Remodel	2004	6,425		10				24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Guest Room Income Offset					(2,232)	(2,232)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,588,373	$ 296,765		$ 293,101	$ (3,664)	$ 6,688,522	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,588,373	$ 296,765		$ 293,101	$ (3,664)	$ 6,688,522	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,588,373	$ 296,765		$ 293,101	$ (3,664)	$ 6,688,522	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,053,424	$ 123,181	$ 119,119	$ (4,062)	3-20 yrs	$ 533,133	71
72	Current Year Purchases	301,210	5,453	5,453		5-25 yrs	5,453	72
73	Fully Depreciated Assets	1,396,549				3-20 yrs	1,396,549	73
74								74
75	TOTALS	$ 2,751,183	$ 128,634	$ 124,572	$ (4,062)		$ 1,935,135	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident	Various	Various	$ 97,782	$ 5,247	$ 5,247	$	3-5 yrs	$ 90,326	76
77	Maintenance	Various	Various	61,494				5 yrs	61,493	77
78	Maintenance	Various	Various	1,219				3	1,219	78
79	See Attach Sch 13A	Various	2002	114,004	7,521	7,521		5 yrs	10,735	79
80	TOTALS			$ 274,499	$ 12,768	$ 12,768	$		$ 163,773	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,742,333	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 438,167	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 430,441	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,726)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,787,430	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage Land	$ 76,532	$	$	86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	8,166,122	227,644	4,549,452	88
89	Rental Property Fixed Assets	233,780	7,862	46,874	89
90	Radio Station	14,161	26	14,064	90
91	TOTALS	$ 8,566,325	$ 235,532	$ 4,610,390	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$	$	$	$ 0		$	37
38	Current Year Purchases				0			38
39	Fully Depreciated Assets				0			39
40					0			40
41	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	Toro 2001	2001	$ 825	$ 115	$ 115	$ 0	5 yrs	$ 363	42
43	Maintenance	Chevy S-10 98	2002	7,508	1,051	1,051	0	5 yrs	3,303	43
44	Facility	Toro mower	2003	7,139	1,428	1,428	0	5 yrs	2,142	44
45	Facility	Ford/Goshen Bus (2)	2004	98,532	4,927	4,927	0	5 yrs	4,927	45
46	TOTALS			$ 114,004	$ 7,521	$ 7,521	$ 0		$ 10,735	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions	N/A						4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ N/A
13.	/2006	$ N/A
14.	/2007	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[ ]
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 40	$	$ 40
2	Books and Supplies		1,094		1,094
3	Classroom Wages (a)		1,587		1,587
4	Clinical Wages (b)		3,175		3,175
5	In-House Trainer Wages (c)		4,299		4,299
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		670		670
9	TOTALS	$	$ 10,865	$	$ 10,865
10	SUM OF line 9, col. 1 and 2 (e)	$ 10,865			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a C1, 2,3	693 hrs	$ 13,252	839	$ 66,710	$ 178	1,532	$ 80,140	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		436	31,937		436	31,937	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 1,2,3	2236 hrs	57,710	1,815	156,119	1,996	4,051	215,825	4
5	Physician Care		visits							5
6	Dental Care	L.10 C 2, 3	visits		12	2,400		12	2,400	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39 C 2	# of prescrpts				58,197		58,197	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 70,962	3,102	$ 257,166	$ 60,371	6,031	$ 388,499	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Good Samaritan Home
Provider #: 0009258
10/01/03 to 9/30/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 343,830	$ 343,830	1
2	Cash-Patient Deposits	23,084	23,084	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	591,930	591,930	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,187,113	1,187,113	5
6	Prepaid Insurance	90,516	90,516	6
7	Other Prepaid Expenses	1,322	5,072	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,237,795	$ 2,241,545	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	25,545,352	25,545,352	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	10,839,084	10,588,373	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,018,983	3,025,682	16
17	Accumulated Depreciation (book methods)	(9,010,319)	(8,787,430)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Cottage & Rental Property	3,955,935	3,955,935	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 34,477,313	$ 34,456,190	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 36,715,108	$ 36,697,735	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 252,703	$ 252,703	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,084	23,084	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	351,864	351,864	30
31	Accrued Taxes Payable (excluding real estate taxes)	59,884	59,884	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,946		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Sch 17C	49,494	49,494	36
37	Prepaid Residents Rent	185,349	185,349	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 953,324	$ 922,378	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 953,324	$ 922,378	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 35,761,784	$ 35,775,357	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 36,715,108	$ 36,697,735	48

***(See instructions.)**

Good Samaritan Home
0009258
9/30/04

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Wage Assignments Payable	0	0
Accrued United Way	198	198
Misc. Employee Withholding	(5)	(5)
Employee Assist Fund Withheld	4,438	4,438
Benevolent Fund Payable	1,535	1,535
Flower Fund Payable	(6,376)	(6,376)
Ceramics Payable	1,550	1,550
Application Fee Payable	28,830	28,830
Medicare Liability	13,017	13,017
Medicaid Liability	23	23
F.W. Education Cost Payable	6,284	6,284
Total Line 36 - Other Current Liabilities(specify):	**49,494**	**49,494**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 33,757,878	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 33,757,878	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,003,905	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,003,905	17
	B. Transfers (Itemize):		
18	Rounding	1	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 35,761,784	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,643,377	1
2	Discounts and Allowances for all Levels	(1,239,121)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,404,256	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	664,226	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 664,226	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	32,841	12
13	Barber and Beauty Care	61,178	13
14	Non-Patient Meals	16,437	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,013	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,313	19
20	Radiology and X-Ray	3,634	20
21	Other Medical Services	60,256	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 290,672	23
	D. Non-Operating Revenue		
24	Contributions	450,777	24
25	Interest and Other Investment Income***	2,117,772	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,568,549	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See Attach Schedule 19E**	39,697	28
28a	**Cottage and Reantal Property Income**	1,281,092	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,320,789	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,248,492	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,751,027	31
32	Health Care	4,819,805	32
33	General Administration	2,158,974	33
	B. Capital Expense		
34	Ownership	438,167	34
	C. Ancillary Expense		
35	Special Cost Centers	978,892	35
36	Provider Participation Fee	97,722	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,244,587	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,003,905	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,003,905	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Good Samaritan Home
0009258
9/30/04

Schedule 19E

XVII. INCOME STATEMENT

Revenue

E. Other Revenue (specify):	Amount
Miscellaneous Income	8,779
Discount Earned Income	481
Guest Room Income	2,232
Van Transportation	20,755
Cottage Services Income	3,900
Application Fee Income	3,550
Total Line 28 - Other Revenue (specify):	**39,697**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,006	2,080	$ 59,740	$ 28.72	1
2	Assistant Director of Nursing	1,968	2,080	40,878	19.65	2
3	Registered Nurses	22,705	25,256	409,344	16.21	3
4	Licensed Practical Nurses	71,561	77,992	1,063,234	13.63	4
5	Nurse Aides & Orderlies	196,269	213,471	2,040,429	9.56	5
6	Nurse Aide Trainees	614	614	4,762	7.76	6
7	Licensed Therapist	2,322	2,929	70,962	24.23	7
8	Rehab/Therapy Aides	12,999	14,681	157,460	10.73	8
9	Activity Director	1,944	2,080	23,853	11.47	9
10	Activity Assistants	12,945	14,277	111,830	7.83	10
11	Social Service Workers	13,336	14,555	126,460	8.69	11
12	Dietician					12
13	Food Service Supervisor	7,570	8,499	118,547	13.95	13
14	Head Cook	7,256	7,891	78,202	9.91	14
15	Cook Helpers/Assistants	60,544	65,647	527,224	8.03	15
16	Dishwashers	10,890	11,997	95,588	7.97	16
17	Maintenance Workers	24,802	27,098	252,928	9.33	17
18	Housekeepers	28,222	31,073	254,678	8.20	18
19	Laundry	10,745	12,028	108,074	8.99	19
20	Administrator	1,928	2,080	96,477	46.38	20
21	Assistant Administrator	1,960	2,080	76,857	36.95	21
22	Other Administrative	7,602	8,145	131,730	16.17	22
23	Office Manager					23
24	Clerical	19,456	21,340	248,041	11.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,048	2,272	31,208	13.74	31
32	Other Health Ca Sch 20A	11,229	12,428	124,627	10.03	32
33	Other(specify) Sch 20A	9,372	10,194	132,205	12.97	33
34	TOTAL (lines 1 - 33)	542,293	592,787	$ 6,385,338 *	$ 10.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	394	$ 13,300	L 1 C3	35
36	Medical Director	Monthly	3,600	L 9 C3	36
37	Medical Records Consultant	Monthly	2,240	L 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,044	L 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	548	L 11 C3	44
45	Social Service Consultant	13	846	L 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	415	$ 30,578		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Good Samaritan Home
0009258
9/30/04

Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nurse Aide Instructor	201	201	$ 4,299	21.39
Nursing Secretary	7,411	8,222	74,504	9.06
Medical Supply Clerk	2,007	2,224	20,582	9.25
Staff Coord.	1,610	1,781	25,242	14.17
Total Line 32 - Other	**11,229**	**12,428**	**$ 124,627**	**$ 10.03**

XVIII. STAFFING AND SALARY COSTS
LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Maintenance Cottages	2,048	2,272	$ 63,231	27.83
Beauty Shop	4,780	5,225	48,716	9.32
General Store	2,544	2,697	20,258	7.51
Total Line 33 - Other	**9,372**	**10,194**	**$ 132,205**	**$ 12.97**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Duffy	Administrator	0	$ 96,477
Judy Graham	Asst Admin.	0	76,857
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 173,334

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heyl Royster Voelker & Allen	Legal	$ 258
Schmiedeskamp, Robertson	Legal	
Neu & Mitchell		8,097
Wade Stables PC	Accounting	16,550
Schiff Hardin LLP	Legal	22,548
Rodemich Appraisal	Appraisal	250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 47,703

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 134,079
Unemployment Compensation Insurance	3,535
FICA Taxes	465,352
Employee Health Insurance	384,784
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Tuition	9,015
Pension Plan	179,651
Employee Medical	12,825
Life Insurance	3,177
Employee Recognition	14,995
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,207,413

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,750
Advertising: Employee Recruitment	12,186
Health Care Worker Background Check	
(Indicate # of checks performed 151)	2,218
Life Services Network	15,746
Council for Health and Human Services	7,092
Various Dues, Licenses, and Permits	2,399
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,391

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,988
See attached Schedule	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,988

* Attach copy of IMRF notifications

**See instructions.

Good Samaritan Home
Provider #: 0009258
10/01/03 to 9/30/04

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	47,703
Legal fees out of period	(183)
Development Cost for Cottages	(250)
Total (agree to Schedule V, line 19, column 8)	47,270

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/03 Ending: 9/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Elevator Repairs	Jan 2001	$ 6,737	3	$ 1,123	$ 2,246	$ 2,246	$ 1,122	$	$	$	$	$
2	Water Heater Repair	Dec 2000	1,311	3	218	437	437	219					
3	Kitchen Garbage Disp.	Apr 2001	4,498	3	750	1,499	1,499	750					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 12,546		$ 2,091	$ 4,182	$ 4,182	$ 2,091	$	$	$	$	$

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/03 **Ending:** 9/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $ CHHS $**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.63 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **88,817** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **97,722**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **16,437**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wade Stables P. C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	819,561	48,744	16,692	884,997	0	884,997	0	884,997
2. Food Purchase	0	670,705	0	670,705	0	670,705	-16,437	654,268
3. Housekeeping	254,678	40,475	21,485	316,638	0	316,638	-3,900	312,738
4. Laundry	108,074	0	18,501	126,575	0	126,575	0	126,575
5. Heat and Other Utilities	0	0	363,529	363,529	0	363,529	0	363,529
6. Maintenance	252,928	42,061	93,594	388,583	0	388,583	2,091	390,674
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,435,241	801,985	513,801	2,751,027	0	2,751,027	-18,246	2,732,781
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	3,922,621	245,030	33,082	4,200,733	0	4,200,733	0	4,200,733
10a. Therapy	70,962	2,174	254,766	327,902	0	327,902	0	327,902
11. Activities	135,683	2,842	9,868	148,393	0	148,393	0	148,393
12. Social Services	126,460	1,006	846	128,312	0	128,312	0	128,312
13. Nurse Aide Training	9,061	0	1,804	10,865	0	10,865	0	10,865
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,264,787	251,052	303,966	4,819,805	0	4,819,805	0	4,819,805
17. Administrative	173,334	0	0	173,334	0	173,334	0	173,334
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	47,703	47,703	0	47,703	-433	47,270
20. Fees, Subscriptions & Promotion	0	0	40,085	40,085	0	40,085	3,306	43,391
21. Clerical & General Office	379,771	39,519	74,310	493,600	0	493,600	-43,555	450,045
22. Employee Benefits & Payroll	0	0	1,207,413	1,207,413	0	1,207,413	0	1,207,413
23. Inservice Training & Education	0	0	3,952	3,952	0	3,952	0	3,952
24. Travel and Seminar	0	0	13,212	13,212	0	13,212	-224	12,988
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	179,675	179,675	0	179,675	0	179,675
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	553,105	39,519	1,566,350	2,158,974	0	2,158,974	-40,906	2,118,068
29. Total General Administrative	6,253,133	1,092,556	2,384,117	9,729,806	0	9,729,806	-59,152	9,670,654
30. Depreciation	0	0	438,167	438,167	0	438,167	-7,726	430,441
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	438,167	438,167	0	438,167	-7,726	430,441
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	58,197	0	58,197	0	58,197	0	58,197
40. Barber and Beauty Shop	48,716	3,845	407	52,968	0	52,968	0	52,968
41. Coffee and Gift Shops	20,258	27,739	0	47,997	0	47,997	0	47,997
42	0	0	97,722	97,722	0	97,722	0	97,722
43. Other (specify):*	63,231	0	756,499	819,730	0	819,730	-819,730	0
44. Total Special Cost Ce	132,205	89,781	854,628	1,076,614	0	1,076,614	-819,730	256,884
45. Grand Total	6,385,338	1,182,337	3,676,912	11,244,587	0	11,244,587	-886,608	10,357,979

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	343,830	343,830
2. Cash - Patient Deposits	23,084	23,084
3. Accounts & Notes Recievable	591,930	591,930
4. Supply Inventory	0	0
5. Short-Term Investments	1,187,113	1,187,113
6. Prepaid Insurance	90,516	90,516
7. Other Prepaid Expenses	1,322	5,072
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,237,795	2,241,545
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	25,545,352	25,545,352
13. Land	128,278	128,278
14. Buildings, at Historical Cost	10,839,084	10,588,373
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	3,018,983	3,025,682
17. Accumulated Depreciation (book methods)	-9,010,319	-8,787,430
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	3,955,935	3,955,935
24. Total Long-Term Assets	34,477,313	34,456,190
25. Total Assets	36,715,108	36,697,735
CURRENT LIABILITIES		
26. Accounts Payable	252,703	252,703
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	23,084	23,084
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	351,864	351,864
31. Accrued Taxes Payable	59,884	59,884
32. Accrued Real Estate Taxes	30,946	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	49,494	49,494
37. Other Current Liabilities (specify):	185,349	185,349
38. Total Current Liabilities	953,324	922,378
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	953,324	922,378
47.Total Equity	35,761,784	35,775,357
48.Total Liabilities and Equity	36,715,108	36,697,735

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	9,643,377
2. Discounts and Allowances for all Levels	-1,239,121
Subtotal - Inpatient Care	8,404,256
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	664,226
7. Oxygen	0
Subtotal - Anciliary Revenue	664,226
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	32,841
13. Barber and Beauty Care	61,178
14. Non-Patient Meals	16,437
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	107,013
18. Sale of Supplies to Non-Patients	0
19. Laboratory	9,313
20. Radiologyand X-Ray	3,634
21. Other Medical Services	60,256
22. Laundry	0
Subtotal - Other Operating Revenue	290,672
24. Contributions	450,777
25. Interest and Other Investments Income	2,117,772
Subtotal - Non-Operating Revenue	2,568,549
27. Other Revenue (specify):	39,697
28. Other Revenue (specify):	1,281,092
Subtotal - Other Revenue	1,320,789
30. Total Revenue	13,248,492
31. General Services	2,669,379
32. Health Care	4,750,602
33. General Administration	2,088,405
34. Ownership	843,087
35. Special Cost Centers	1,014,094
35. Provider Participation Fee	97,455
37. Other	0
40. Total Expenses	11,463,022
41. Income Before Income Taxes	1,785,470
42. Income Taxes	0
43. Net Income or Loss for the Year	1,785,470

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